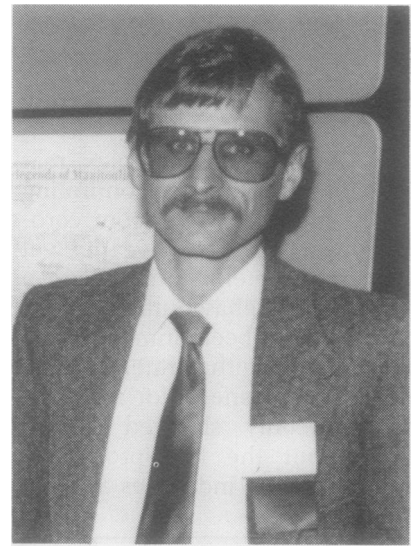
# Family medicine departments not doing their job, rural MD asserts

Amy Chouinard

The number of physicians, medical students and residents who turn out for recruitment tours by the Underserviced Area Program of the Ontario Ministry of Health has not changed significantly in recent years, but a family physician who accompanied the five-city tour last fall believes the numbers of trainees who are adequately prepared for rural practice have declined markedly. The culprit, he thinks, is the urban bias in family medicine training programs.

The ministry reported that 402 physicians, residents and medical students attended receptions held during the 10th annual recruitment tour, an average number. But, says Dr. Wayne Bullock, one of eight medical practitioners helping with the recruiting, "During a week of touring and recruiting [in Ottawa, Kingston, London, Hamilton and Toronto], I talked to fewer than 10 residents from family practice units. In some cities, no residents came out at all, and there might be 30 or 40 people training. Not a single person showed interest in the underserviced areas. Many residents feel unprepared for isolated practice, and they find it easier to stay where they can send patients on to the emergency room to be seen by someone else."

Bullock, who practises on Manitoulin Island, says family medicine departments have badly neglected "nuts-and-bolts"



**Bullock: "real doctors, real patients"**

medicine — "the lifesaving procedures that all physicians used to know".

Bullock maintains that family medicine programs are doing "a terrible job" preparing doctors for rural practice. "A generation ago when people took rotating internships and were trained by other specialists, graduates were better trained and I think more likely to come to a northern community", he says.

"A 2-year mandatory licensing program would increase the quantity, but not the quality, of training. When I went to Tobermory [Ont.] at the end of my residency I learned more procedures in 1 week than I had in 2 years in the south. We were delivering babies, putting casts on fractures, cutting lumps and bumps out of people, taking blood, inserting IUDs, doing Ds and Cs. Drs. Ralph Suke and George Harpur taught me how to do these procedures, [but] in the family practice units, not a single doctor delivered babies or worked in the emergency room. We were discouraged from learning procedures.

"The family practice training centres have a lot of dead weight among the doctors they have training people and rather than have residents work in these urban settings we should be sending them out to work with real doctors, with real patients, in real places like Little Current."

Bullock began practising in Little Current in 1986 and a year later moved down the road about 30 km to Manitowaning to become "the first doctor in about 25 years" to serve that town of 500. He is a beneficiary of Ontario's bursary program and says, "Becoming a good physician is the most important benefit of practising in a rural area. The greatest advantage is the opportunity to develop interpersonal skills and competence — to grow as a person. About 30% of my practice is from the nearest reservation and the rest from the town and surrounding area, so I have exposure to the native peoples. The incentive grants don't compare with the money city doctors can make by seeing a lot of patients, but there are other benefits, like recreation. I can cross-country ski and golf 5 minutes from home. It's a good place to raise children."

Because Bullock grew up in a rural area he may have been more eager than urban classmates to take advantage of the opportunities provided by the bursary program. The ministry

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# Ontario legislation gives health minister new weapon

Ontario's Independent Health Facilities Act, which received second reading Nov. 7, 1988, could give the province's minister of health the power to redistribute physicians, not through incentives such as those being promoted by the Underserviced Area Program, but through disincentives. Conceivably, her ministry could hold fee increases so low that physicians opening new practices could not cover their overhead unless they practised in provincially funded facilities. (This year's fee increase, 1.75%, was a take-it-or-leave-it offer imposed upon Ontario doctors by the province late in 1988.)

As drafted, the act requires licences for any health facility that is providing services covered by the provincial health insurance plan and is currently charging users a fee to help meet overhead costs. It outlaws user fees and empowers the ministry to pay part or all of the operating costs of licensed facilities.

The legislation would give the minister authority to revoke or refuse licences on the grounds that the facilities are not needed in a particular area or that they would be too expensive for the public purse. The minister would not have to provide any reason for revoking or refusing a licence, and the would-be licensee would have no recourse to appeal.

**Caplan: limits on way?**

Ministry-appointed assessors — "one or more employees of the Ministry or other persons" — would be authorized to seize and copy records, including patient records, a stipulation that is causing major concern among the province's doctors (*Can Med Assoc J* 1988; 139: 798).

Although the background information released with the act maintains: "This act will not affect the provision of insured services in a doctor's routine office practice", the bill does have implications for private practice if fees increase more slowly than overhead costs.

On introducing the bill, Ontario Health Minister Elinor Caplan commented: "We can use funding incentives under the act to promote and foster — for the first time — viable expansion of community-based health care in Ontario."

Ironically, Caplan said in October, a week before the annual recruitment tour by her ministry's Underserviced Area Program, that Ontario has too many doctors and that the government is considering acting alone to limit their number. The Independent Health Facilities Act may not provide a way to reduce physicians' numbers, but it will deliver the means to move them around.

does not know what proportion of bursary recipients have rural backgrounds or have had a stint in rural practice during their training.

Dr. John Hammett, manager of the Underserviced Area Program and a former medical consultant to the program, says the bursaries do encourage people to set up practice in underserviced areas. "We award about 50 bursaries a year, and I would say roughly 20 to 25 of the physicians establishing practice annually in Northern Ontario are bursary recipients. Bursaries of $7500 are available for students in the last 2 years of medicine, occupational therapy, physiotherapy, speech pathology, audiology, dentistry and chiropody. The student returns 1 year of service for each year of bursary."

Hammett says an incentive grant program is available for physicians in practice that complements the student bursaries. It provides $10 000 tax-free annually for up to 4 years, money over and above what the physician earns through fee-for-service payments.

The bursaries are funded by the Ministry of Northern Development and Mines, with the Ministry of Health covering promotion and recruitment costs. "The tour is a very small part of our program", says Hammett. "The main thrust is speaking to classes of undergraduates at the universities. We travel to national and provincial meetings and we advertise widely. The budget [$9 million] also covers the costs of 16 nursing stations in Northern Ontario."

For Bullock, the incentive grants and his low overhead costs ensure an adequate income: "My wife does a lot of the work; I pay a nurse a salary but pay no rent. My office belongs to the township [but] it's small and is shared with the dentist so I can't be available as often as people in the community would like. My Christmas wish would be to have a community health clinic."■